STATEWIDE WASTEWATER OPERATOR TRAINING CENTER DEPARTMENT OF HEALTH, STATE OF HAWAII HONOLULU, HAWAII

REGISTRATION APPLICATION

(Print Name)	LAST		FIRST	M.I.	
MAILING ADDR	ESS	Street	City	Zip Code	
TELEPHONE (E	BUSINESS)				
EMPLOYER					
CERTIFICATION	N GRADE				
TITLE OF COUF	RSE		ISLA	AND	
DATE(S) OF C	OURSE				
I ENCLOSE \$ _		(IF APPL	ICABLE).		
Please make che	eck or money o	der payable to the	Department of Healt	h, State of Hawaii.	
			TRAINING CENTER OR TO THE FIRST D		
Mail completed	Mail completed application to:		OFFICIAL USE	ONLY:	
Administrator of the Training Center State of Hawaii, Dept. of Health 1350 Sand Island Parkway, Bldg. 3A Honolulu, Hawaii 96819		h	Date:Check No Amount Receive	Date: Check No Amount Received:	
I certify that I have	ve met the prere	equisites of the cou	ırse.		
APPLICANT'S SIGNATURE			D	Date	
SUPERVISOR'S APPROVAL			D	Date	
NOTEO:					

NOTES:

- 1. <u>STATE AND COUNTY WASTEWATER TREATMENT EMPLOYEES</u>. Please submit application to supervisor. Supervisor will submit all applications to county superintendent who will compile and forward all names to the Administrator.
- 2. <u>ALL OTHER NON-MUNICIPAL AND NON-WASTEWATER EMPLOYEES</u>: Forward applications and tuition directly to the Administrator.